

FILED JUN 12 1944

Registration District No. _____

Primary Registration District No. 5605

Registrar's No. 10

1. PLACE OF DEATH:

(a) County JOHNSON
(b) City or town KNORNOSTER (AIR BASE)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: STATION HOSPITALS A.A.F. Of Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT
FULL NAME

MICHAEL CASSIDY

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased 5 - 28 - 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
6 hr. 20 min.

9. Birthplace KNORNOSTER, SAAF MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name LT. EDWARD L. CASSIDY
13. Birthplace CHICAGO ILL. 1
(City, town, or county) (State or foreign country)
14. Maiden name KATHLEEN THAYER
15. Birthplace ELLENBURG WASHINGTON
(City, town, or county) (State or foreign country)

16. (a) Informant LT. MARJORIE A. DERINGER
(b) Address S.A.A.F. KNORNOSTER

17. (a) BURIAL (b) Date thereof 5-29-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director GILLESPIE
(b) Address SEDALIA Mo.
5-29-44 (c) Mrs C. A. Saults
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JOHNSON-1
(c) City or town KNORNOSTER
(If outside city or town limits, write "RURAL")
(d) Street No. S.A.A.F.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 28TH
year 1944 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4:10 Am
May 28, 1944, to 10:30 Am May 28, 1944;
that I last saw him alive on May 28, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
broncho pneumonia
Due to Premature birth
at 7 1/2 months

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
159

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature A.E. Steen (M. D. or other) MD
Address Sedalia Army Air Field Date signed 5/29/44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.